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ABSTRACT

Case management has become a core component in the delivery of long term care services. It is widely viewed as a mechanism for linking and coordinating segments of a service delivery system (within a single agency or involving several providers) to ensure the most comprehensive program for meeting an individual client's needs for care. Although there is some consensus regarding generic case management functions, the role of case manager is implemented with considerable variation and has different meanings in various settings. This paper presents a model for analyzing case management that is contingent on the delivery system. Four distinct long term care delivery system types are examined: Channeling, Basic and Complex, the Social/Health Maintenance Organization, and the Veterans Administration. Each is described with specific emphasis on the underlying financial arrangements, target populations, and gatekeeping mechanisms. The main argument of this paper is that the case management function that is implemented in each of these delivery systems will be differentially effective and efficient given the assumptions, goals, parameters, and constraints operating in the four systems. (BL)

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COMPARING CASE MANAGEMENT SYSTEMS

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Comparing Case Management

Case management has become a core component in the delivery of long term care services. It is widely viewed as a mechanism for linking and coordinating segments of a service delivery system (within a single agency or involving several providers) to ensure the most comprehensive program for meeting an individual client's needs for care. Although there is some consensus regarding generic case management functions, the role of case manager is implemented with considerable variation and has different meanings in various settings. This paper presents a model for analyzing case management that is delivery system contingent. That is, the kind of case management that is implemented within a delivery system will reflect and address the specific characteristics of that system.

Four distinct long term care delivery system types will be examined: Channeling, Basic and Complex, the Social/Health Maintenance Organization and the Veterans Administration. Each of these represent different approaches to organizing, financing and delivering long term care services. Each is described with specific emphasis on the underlying financial arrangements, target populations and gatekeeping mechanisms. These four long term care delivery system approaches can be specified and their distinguishing characteristics identified. They all involve a common element, case management. A key component of the case management role is authority over resource allocation in case planning. The main argument of this paper is that the case management function that is implemented in each of these delivery systems will be differentially effective and efficient given the assumptions, goals, parameters and constraints operating in the four systems.

Why Case Management?

In this analyses it is important to address the basic issues which provide the context for case management activities. It is important to emphasize the inter-relationships between client circumstances and the characteristics of delivery systems set up to serve elders. In essence, the question is "why case management?"

With increasing age, particularly for those over age seventy-five, a large portion of elderly become more at risk of multiple medical problems, functional disabilities, social losses and socio-economic dislocations. In some instances these difficulties are precipitated by a catastrophic event such as an acute illness, an accident or loss of a spouse. Many times these problems develop slowly and incrementally over time. Failing health, increasing difficulty in getting around and erosion of savings and income are interdependent. Problems in one area exacerbate problems in others.

Effective care of impaired elderly, therefore, is dependent on being able to respond rapidly to major difficulties as well as to provide early interventions for individuals who show signs of becoming frail. Ideally, the response in both instances should be comprehensive, offering a full array of services necessary to restore and maintain the highest feasible level of functional independence that enhances client choice. This goal requires a combination of health and social services for that is where long term care is located, at the intersection of two artificially separated delivery systems. For frail elderly patients with functional deficits, gaining access and coordinating services from these complex delivery systems becomes a formidable task.

Enter case management. It is clear that in the current long term care service delivery environment there is no single coordinating mechanism for selecting and authorizing the amount, duration and scope of specific services

for individuals. Furthermore, incentives to use less costly services are absent, case management is generally viewed as a mechanism to enhance coordination and accountability.

Case Management Goals and Functions

Steinberg and Carter have identified eight goals for case management from documents provided by various programs for elders across the country.[1]

1. To target individuals most at risk of nursing home placement.
2. To contain costs (or making efficient use of scarce resources).
3. To provide equity for underserved groups.
4. To improve access for elderly clients.
5. To enhance service coordination (or building the system).
6. To fill gaps and increase the supply of services.
7. To serve clients in the least restrictive environment.
8. To evaluate and conduct research.

Are case managers being asked to address too many, partly contradictory goals? Is it possible to contain costs and increase the supply of services simultaneously? Perhaps, but only under specific circumstances. What is striking about this list of goals is the fact that case management is an intervention at two levels - the client level and the system level. It is at once an effort to enhance the quality of service delivery to individual clients and to alter the delivery system. Frequently, case managers' capacity to modify local delivery systems is obscured when attention is focused on what have become familiar functions associated with case management. These are:

-- Outreach: Identifying and attracting the most appropriate target population.

-- Screening

-- Comprehensive assessment

-- Care planning

-- Arranging services

-- Monitoring

-- Reassessment

Screening, assessment and care planning are tasks that are routinely identified as core case management activities. The dynamics of care planning however have received little analytic attention.[2] Care planning involves the translation of information gathered during assessment into a service plan for the client. This is a set of decisions that produces a package of services. Fundamentally, developing a care plan is a resource allocation process involving a range of decisions about how many of what kinds of services a client will receive from which service providers. A case manager, with responsibility for developing care plans involving multiple providers in a local community or involving multiple professionals in a single organization is operating as a resource allocator. Planning for care, the basic set of resource allocation decisions, can also be the responsibility of an interdisciplinary team. In either case, decisions are made which result in the allocation of scarce resources within a target population.

Long Term Care Delivery Systems

Over the past ten years we have witnessed increased efforts to design, demonstrate and evaluate new approaches to the delivery of long term care. Regardless of the models developed, they all incorporate some form of case management. Zawadski and Ansak[3] have identified three models of long term care delivery systems: the traditional system, brokered approaches and consolidated models.

The traditional system may be more accurately described as a non-system. It is the non-system of fragmented, discontinuous and uncoordinated programs,

providers and services. There is limited accountability and few incentives for cost-effective care planning.

Brokered models operate within the context of fragmented funding among agencies providing long term care services. Essentially these efforts have been designed to test the premise that major difficulties in the current long term care delivery system are problems that can be solved through client centered case management. The brokered approach is most recently exemplified by the National Long Term Care Channeling Demonstration (which is described below), and also includes previous efforts such as Triage, Access, the Wisconsin C.C.O. and Georgia's Alternative Health Care Program.

While many of these projects operated with funding waivers, some in both Medicare and Medicaid, they were basically focused on social services oriented interventions and did not have direct control over utilization of acute and ambulatory health services. Case managers, in these projects, are primarily linkage agents. Alternatives to institutional care were seen as community based social services that could be provided in lieu of nursing home placement. Often costs and utilization in acute and ambulatory health care were not controlled because these projects did not have the authority to control service delivery in these areas.

The third type of long time care system, which is currently being developed is the consolidated model. These are perhaps best exemplified by the Social/HMO project sites and the On Lok effort. These models encompass system level reform and change the way in which services are funded and provided. The key to consolidated projects is integrated, prepaid, capitated funding in combination with a single provider system which delivers a comprehensive range of acute, ambulatory and long term care services under one administrative umbrella. Provider risk is increased and cost consciousness is emphasized.

The role of the case manager in consolidated long term care delivery systems represents a departure from the community based brokered models. Here the focus is more on intra-organizational coordination, since most if not all services are provided by a single organization and perhaps more significantly the emphasis is on interprofessional coordination, since a comprehensive range of services (from acute, through ambulatory to long term care) are delivered requiring the interaction of an interdisciplinary group of health care professionals. Case managers operating in these programs have the opportunity to work out the linkages and relationships between health and social service professionals and to demonstrate how interdisciplinary collaboration can function effectively within a pre-paid system.

Core Delivery System Characteristics

Present and future long term care delivery systems will be structured around three core design elements: targeting, gatekeeping and financial arrangements or reimbursement. Choices among options in these three categories combine to create models of long term care delivery systems.

Targeting involves the specification of sub-groups within a population whose members are seen as the most appropriate recipients of services. For example, some community based long term care programs have targeted services to vulnerable, frail individuals, those persons at risk of nursing home placement. Outreach, screening and assessment are central activities in the implementation of targeting. It is seen as key to controlling costs and possibly achieving savings.

Gatekeeping is the second core delivery system characteristic. Gatekeeping mechanisms are designed to control the number and types of clients or patients who have access to services, particularly high cost services like institutional care. For example, nursing home pre-admission screening efforts are designed

to limit access to nursing home beds to frail individuals with significant medical problems and functional deficits, elders who lack social supports, and reside in inappropriate housing. Targeting and gatekeeping are closely related. Effective and efficient targeting will influence the kinds of gatekeeping mechanisms that are imposed in a delivery system. Furthermore, both targeting and gatekeeping will affect the costs of long term care services.

The foundation of long term care service delivery is the underlying structure of financial arrangements. Callahan[4] has identified several market inefficiencies in the provision of long term care services which have contributed to rising long term care costs. These inefficiencies have resulted in the absence of needed services, the use of high cost institutional care, the use of expensive and frequently redundant services and a poor match between client needs and services provided. As concern over long term care costs mounts various innovative financial approaches have been developed. These include: caps on budgets (agency and client care plans); client cost sharing (deductibles and co-payments) pooled funding, case mix reimbursement formulae, pre-paid and capitated funding, long term care insurance and life care communities.

In the next section of this paper four distinct long term care delivery systems are examined in terms of their targeting, gatekeeping and financing features. These delivery systems are the two models of Channeling (Basic and Complex), the Social/HMO project and the Veterans Administration. These characteristics are summarized in Chart 1.

Channeling

The National Long Term Care Channeling Demonstration is operating in 10 sites around the country.[5] The demonstration model is based on the central idea that it is necessary to direct clients to a set of services that meet

their assessed needs more appropriately. The projects are experimenting with two approaches (basic and complex) to organizing and coordinating services and structuring funding through case management. The two models share a core set of functions: outreach, screening, comprehensive needs assessment, care planning, and case management. These core channeling functions are designed to locate the target population most appropriate for community care, to provide necessary information and to arrange for and coordinate services that most appropriately and efficiently meet those needs. The channeling initiative is focused on community based long term care. It does not include acute and ambulatory health care services.[6]

°Targeting

The target population for both models in the Channeling demonstrations is the same except that clients in the complex model must be covered by Part A of Medicare. Globally they are individuals over age 65 who are at risk of nursing home placement, but who could remain in the community with the assistance of community based long term care services and the facilitation of those services by a channeling case manager. More specifically, the target population for channeling are individuals over age 65 with significant functional impairment. Minimum impairment criteria for participation in the channeling demonstration are: two moderate ADL impairments or three severe IADL impairments or two severe IADL impairments and one severe ADL impairment.

Further targeting criteria are the presence of unmet needs and/or the fragility of the social supports. Either the present unmet service needs of the potential client must be predicted to continue for at least six months, or the person's informal support system must be determined to be at the breaking point and on the verge of collapse.

There are two residence criteria. To improve the probability that participants are appropriate for community living, they must either be living in the community or if living in a nursing home, they must be certified for discharge to the community within three months. In addition, the client must reside within the geographic catchment area covered by the demonstration.

There are no eligibility criteria related to income resources or payor. Decisions about project participation are based on the targeting variables described above, not on income. Both Medicare and Medicaid waivers are in effect. These remove eligibility restrictions and coverage limitations.

Basic Channeling

The basic channeling model locates a coordinating mechanism (case management) in the ongoing delivery system in a local community. The basic model of Channeling seeks to test the premise that the main problems in the current long term care system are essentially concerns about inadequate information, restricted access and poor coordination. These problems, it is hypothesized, can be alleviated by client centered case management. The basic model is a brokered approach in which case managers are dependent upon the characteristics of the delivery system in which they are located. Limited gap filling funds are available for direct purchase of community based services to fill in gaps for individual clients. Given the limited amount of these funds, however, case managers rely primarily on informal support system members, formal agencies and publically funded programs for care planning.

°Gatekeeping

The basic model of channeling is designed to improve access and coordination of services for a frail target population of elders. Case managers working in basic channeling sites do not act as gatekeepers. They do not control access to high cost services or possess authorization power in the provision of services.

°Financing/Reimbursement

The basic channeling approach does not alter the structure of funding. Funds from several sources are involved (Medicare, Medicaid, Title 3 of the Older Americans Act, Social Services Block Grant), however, these funding streams remain separate and distinct. All services for Channeling clients must be provided subject to current eligibility and delivery requirements of various programs.

Complex Channeling (Financial Control)

The complex model extends and elaborates the basic channeling concept by including additional features that enable the project to address issues of cost control directly and to improve the availability of services for its clients. The complex model significantly differs from the basic approach in terms of its gatekeeping and reimbursement mechanisms. Six program elements, included in the complex model, are intended to alter provider incentives and to control costs.

°Gatekeeping

Expanded service coverage: In the complex model funding is extended to include a range of community based services not usually reimbursed by public programs or which may not be available in some local sites across the country.[7]

Authorization power: Case managers can authorize the amount, duration and scope of services paid from the pooled funding that supports the project. They can modify, limit or terminate services provided in response to clients' changing needs or the failure to providers to deliver quality services.

Cap on average expenditures: A maximum amount is set on average expenditures for services per client for the project's caseload as a whole. The purpose of the ceiling is to prohibit expenditures in excess of the average

of the state rates for intermediate care facilities and skilled nursing facilities. Average annual expenditures are not permitted to be above 60% of the average of the state ICF and SNF rates.

Limits on individual expenditures: Costs of individual care plans for clients can vary under the cap on average expenditures. There are limits on the annual expenditures for each individual set at 85% of the average of the state ICF and SNF rates. Approval must be received for care plans in excess of the 85% limit. In developing care plans, case managers must consider these financial limits.

°Financing/Reimbursement

Pooled funding: Expansion in service coverage is paid for from a pool of service dollars. The pool is composed of Medicare, Medicaid, and other government programs (Older Americans Act, Social Services Block Grant). Coverage for the expanded service package does not depend on eligibility for a particular categorical program. However, since the complex model is partially funded by Medicare, clients participating at complex channeling sites must be covered by Part A of Medicare.

Client cost sharing: In an effort to target public funds on those clients identified as most in need, persons whose incomes exceed a protected amount (200% of the state's Supplemental Security Income eligibility level and a food stamp bonus) are required to contribute to the costs of their services. These clients are not asked to pay for services that are available at no cost, nor are they required to pay more than the cost of services received. The cost sharing feature is designed to encourage participation by individuals who fall into the spend down population of persons whose incomes are above the Medicaid income eligibility level as long as they are in the community,

but who would spend down to Medicaid eligibility after being institutionalized.

It is important to stress two points about the Channeling initiative. First, both models operate in the interorganizational environment of the community long term care delivery system where coordination among providers is the main task. Both the basic and complex models are brokered approaches, with the complex (financial control) model including features designed to foster greater accountability and cost containment. Second, the channeling projects are not responsible for and have no direct control over the provision of acute and ambulatory health care services. While channeling case managers may follow their clients during acute episodes, their authority does not extend into the health care delivery system.

The Social/Health Maintenance Organization (Social/H.M.O.)

The Social/Health Maintenance Organization represents a major reform in the delivery and financing of health and social services for the elderly. It is "a managed system of health and long term care services. Under this model, a single provider entity assumes responsibility for a full range of acute in-patient, ambulatory, rehabilitative, extended care, home health and personal care services under a fixed budget which is prospectively determined." [8]

°Targeting

In the Social/H.M.O. targeting takes on a different meaning. The coverage available through the Social/H.M.O. benefit package is marketed to interested persons. Elderly persons residing in the service area are voluntarily enrolled. The Social/H.M.O. is designed to test the notion that a wide variety of elderly persons are interested in protecting themselves from the risks of needing long term care services and that they are willing to pay for this protection. While enrollment is voluntary, it is necessary to avoid the problem of adverse

selection, where only those who currently need long term care service would buy the policy. The Social/H.M.O. providers therefore seek to enroll a mix of well, moderately impaired and frail elderly which is representative of the total elderly population. The risk for long term care services is spread across a representative population of elderly enrollees.

°Gatekeeping

The total range of services in the Social/H.M.O. is made available to enrollees through one administrative structure. The single provider is responsible for both acute and long term care needs of enrollees. This integration is designed to provide easier access to appropriate services by eliminating artificial barriers between medical and social supportive services.

Provider risk is a central feature of the Social/H.M.O. concept. Given prospective payment, providers must keep costs below the predetermined aggregate capitation rate or incur losses. The provider organization assumes financial risk in the case of expenses exceeding the prepaid amount. This creates an incentive for the provider to control total costs, to provide preventive services and to substitute lower cost community based services for higher cost hospital or nursing home care where appropriate. In order to accomplish these goals, gatekeeping mechanisms are essential. Controlling access to costly care modalities and providing lower cost substitutes requires explicit gatekeeping decision rules.

The single provider system permits the development of centralized authorization power. This authority is located with the case managers whose responsibilities include assuring that appropriate services are provided to those who need them and only to those who need them.

*Financing/Reimbursement

Medicare, Medicaid and private insurance premiums are pooled and rates will be prospectively determined on a capitation basis. The funding pool could also include Older Americans Act funds and support available through block grants. In order to protect against adverse selection, actuarially sound Medicare and Medicaid rates for specific subgroups of the enrollee population are required. Prospective, capitated payment in the Social/H.M.O. is a major departure from the fee for service financing approach.

Social/H.M.O. enrollees would pay a monthly premium, the primary client cost sharing mechanism. Premium payments eliminate multiple co-payments and deductibles in the Medicare program.

The Veterans Administration

The Veterans Administration has been a major provider of chronic care, particularly for service connected disabled and long term psychiatric populations. It has been a leader in the development of rehabilitation medicine through its mission to serve disabled veterans.[9] Meeting the health and social service needs of the growing numbers of aging veterans is a major challenge facing the V.A. The number of veterans age 65 and older will triple between 1981 and 2000. By the year 2005 the number of veterans over 75 years of age, a group with greater health problems, is expected to be six times greater than it was in 1981. While not all eligible older veterans will choose to use its services, the V.A. anticipates increased demand for care from this age group.[10] In this context, the existing configuration of V.A. services may be unable to meet the needs of the elderly veteran population. Currently, the V.A. is engaged in a planning process to develop a V.A. plan for older veterans which will set forth directions the V.A. intends to follow to meet the needs of older veterans. The V.A. is an emerging long term care delivery system. Therefore,

the following discussion will be somewhat speculative given the current planning effort.

The Veterans Administration is a national health care system which provides care to eligible veterans. The V.A. operates 172 hospitals, 16 domiciliaries (average daily census in FY 1982, 7,087), 98 nursing home care units (9,239 beds), and contracts for care with community nursing homes (average daily census in FY 1982, 9,525). In collaboration with states, the V.A. operates state veterans homes in thirty-four states. The estimated veterans census for FY 1983 in the state homes was 4,856 domiciliary, 6,744 nursing home and 590 hospital. The V.A. also sponsors a Hospital Based Home Care Program in 43 sites, a Residential Care Home Program (average daily census in 1982 of 12,800 veterans in 3,124 homes), as well as limited Adult Day Health Care and Respite Care. The V.A. has stimulated the development of Geriatric Evaluation Units and Hospice programs in the system.[11] Although the V.A. is a major provider of care for chronically ill populations it operates from an acute care, hospital base. Recent V.A. planning documents have called for the provision of a comprehensive package of acute, ambulatory and long term care services for a well defined target population of eligible veterans. Comprehensive services would be provided through collaborative arrangements with community agencies.[12]

°Targeting

In order to address the issue of targeting within the V.A. it is necessary to discuss eligibility. Eligibility for services within the V.A. is a complex patchwork of criteria including whether the veteran has a service connected disability and if so its severity. Further, eligibility varies with the period of time during which the veteran was on active duty. A 1977 National Academy of Sciences Report describes the V.A. mission as follows: "to operate a

system of hospitals and associated outpatient and long term care facilities for veterans with service-connected disabilities and to provide both acute and long term care to veterans without service connected disabilities to the extent that spare capacity in V.A. facilities permits."[13] Service connected disabled veterans have higher eligibility than non-service connected. For veterans over age 65, the inability to pay for their care has been removed as an eligibility criteria. This however does not guarantee that older non-service connected veterans will actually receive care. This will in part be determined by the excess capacity available at V.A. locations across the country.

The issue of targeting has been addressed by the Special Medical Advisory Group, Task Force on the Geriatric Plan.[14] This group did not address the complex issue of eligibility in the V.A. system, but did endorse the use of two targeting criteria, age and risk of placement in a nursing home. Primary emphasis is to be given to veterans over the age of 75 who are vulnerable. While indicators of frailty and vulnerability were identified (e.g. functional impairment, absence of informal supports, inappropriate living arrangements), they were not operationally defined. This at risk population would be targeted for a package of comprehensive services and care coordination.

°Gatekeeping

At present, the V.A. does not utilize gatekeeping mechanisms in order to control access to high cost services. Durham has argued, "the V.A. provides a prime example of this shortcoming in the care of the chronically ill and disabled. V.A. Medical Centers are funded on the basis of their inpatient bed utilization. Even administrators who favor outpatient health care programs find that their 'bread and butter' must come from a high inpatient bed census. Thus, the incentives for community-based care are absent from the local medical center."[15]

The V.A. does not participate in nursing home preadmission screening programs where they exist. Nursing home placement decisions are made autonomously. Further, the V.A. is exempt from certificate of need requirements and has its own internal planning for facility expansion and construction.

°Financing/Reimbursement

The V.A. is a prospectively budgeted system. Budgets are prepared for each V.A. Medical Center for a fiscal year. At present reimbursement formula are based on bed occupancy and inpatient care. Local hospital directors stretch their budgets to serve as many veterans as possible. Emphasis on inpatient bed census as a basis for reimbursement, however, leads to disincentives for community care. If the V.A. wants to make available a more comprehensive array of services for older veterans, it will need to develop fiscal incentives which will reward outpatient and community based care in its funding formula.

A Delivery System Contingent Model of Case Management

Four distinct long term care delivery systems have been described in terms of their targeting, gatekeeping and financial/reimbursement features. In this section, the case management role is examined in terms of four characteristics: span of authority, scope of authority, financial incentives and centralization of resource control.[16] The paper concludes with a discussion of the case management function within each of the four long term care delivery systems along these dimensions. The discussion is summarized in Chart 2.

Span of authority refers to the width of the range of services over which the case manager has control. A wide span would entail the authority to allocate funds for acute care, home care and nursing home care, for example. Case managers operating with the widest span would control allocation of all funds available to members of a specific population from a variety of different sources

(for example, Titles XVIII, XIX, and XX of the Social Security Act, and Title III of the Older Americans Act).

Scope of authority in the allocation of funds refers to the breadth of impact the case manager has in different portions of the delivery system (for instance, the manager's influence on, access to and use of funds for nursing home services and acute care). Case managers operating with a broad scope would control for prior authorization for services, preadmission screening to nursing homes, discharge planning from hospitals and follow-up of clients admitted to nursing homes. These mechanisms enhance the case manager's ability to target services to identified subpopulations of clients effectively and efficiently by controlling access to high cost services. Case managers with a narrow scope would only monitor the development of service plans and contracts with providers.

Case management can be designed to use financial incentives and sanctions to change the character of the long term care delivery system and the behavior of service providers. Incentives and sanctions could take several forms: target budgets, limits on budgets for individual clients, ceilings on budgets for catchment areas or capitation of service costs.

The extent to which case managers have discretion over the allocation of resources is closely related to the degree to which control of resources is centralized. In the current system of fragmented funding, case managers are likely to control only a portion of the resources for any given client. Fragmented funding in a fee-for-service system allows providers to charge the costs of services received by eligible clients directly to programs for which the client is eligible. This makes it difficult to contain costs.

°Basic Channeling

Case managers operating within the context of the basic channeling demonstration project model are brokers. Their span of authority is restricted to community based long term care services and does not extend to acute and ambulatory care. These case managers must work within the established eligibility and program operation guidelines of various programs as they presently exist. Fragmentation is given and the case managers do not have the necessary scope of authority to control access to and funding for acute and long term care services. In the basic channeling model, case managers provide a single point of entry and contact for clients within the traditional fragmented non-system of long term care service delivery.

These case managers are not equipped with financial incentives which would permit them to modify provider behavior. Funding remains fragmented and case managers work within the constraints imposed by this funding structure. The basic channeling intervention's main feature is the presence of a weak form of case management which emphasizes the provision of information, the improvement of access and voluntary coordination among service providers.

°Complex Channeling

The complex model of channeling represents a departure from previous brokered long term care delivery systems. Here is the emergence of case management as a system level intervention. This channeling model includes components which are aimed at system level reform, including: pooled funding (Medicare, Medicaid, some title 20 and title 3 of the OAA); authorization power given to case managers (including the power to authorize services across multiple funding streams and to limit, alter or terminate services from provider directly). These features serve to make the case manager more directly accountable for their

care plan decisions. Furthermore, case managers working in the complex channeling projects have to operate within caps on average expenditures for clients in their case loads, as well as caps on costs incurred for individuals. Complex channeling models also have the capacity to change the local delivery system in which they operate through the use of funds available for service expansion.

Case managers working in the complex channeling sites are operating with a somewhat centralized funding structure. Pooled funding, however, does not extend to acute and ambulatory health care. These case managers do have moderate span and scope of authority. They control allocation of funding across the range of covered community based long term care services and given the capped budgets with which they work they also have moderate scope of authority in allocating services in care planning. Financial incentives within the complex channeling model provide limits within which case managers develop care plans and affect rates negotiated with community providers. The complex channeling model introduces several features designed to enhance cost containment through budgetary limitations placed on care plan decision making and through client contributions to the cost of their care.

It is important to highlight two points regarding both channeling models. Case managers, in both instances, are operating in the interorganizational environment of the community long term care delivery system where coordination among providers is the main task. Secondly, case managers are not responsible for and have no direct control over the provision of acute and ambulatory health care services.

*The Social/H.M.O.

To date there is no operational experience that can be analyzed from the Social/H.M.O. demonstration sites. Discussion of case management in this

project is therefore primarily theoretical. The Social/H.M.O. is a dramatic departure from other systems engaged in the delivery of long term care services. It incorporates the provision of an inclusive benefit package, delivered by a single provider, financed by a pooled, pre-paid and capitated funding source. Fragmentation of funding and delivery systems is therefore eliminated. Given increased provider risk introduced through the payment mechanism, there are strong incentives for cost conscious care planning on the part of case managers. Pooled funding creates centralized resource control.

Theoretically, case managers in the Social/H.M.O. project sites will have both broad span and scope of authority owing to the single administrative structure of the provider organization and the need to control access to high cost services within a pre-paid funding structure. Financial incentives are strong for providing services that may be less costly alternatives to high cost institutional acute and long term care services. The enrollment of a representative population of elderly provides an opportunity to learn more about the relationship between changes in client circumstance and service responses over time within the context of a prospectively budgeted system. The Social/H.M.O. service delivery context provides an environment in which a strong model of case management can be implemented. The challenge for Social/H.M.O. case managers lies in the negotiation of relationships and decision making with physicians and in the development of decision rules to guide care planning.

°The Veterans Administration

Case management for older veterans does not currently exist within the V.A. system. The case management function is present in programs that are specifically focused on sub-populations of disabled veterans (e.g. the spinal cord injured, the blind). If the V.A. plans to introduce case management for

older veterans, there are several approaches that are possible. This discussion is guided by an underlying assumption. The V.A. is a hospital based, acute care oriented system. As such it will not elaborate a set of social services oriented community based long term care services in house. Rather, it is more likely that the V.A. will establish collaborative arrangements with community providers[17] in order to improve access to a more complete continuum of care for its older veteran population. One major decision will be whether the V.A. plans to provide case management itself or whether it could consider contracting for case management from community agencies.

Whatever direction the V.A. takes it will be necessary to confront the issue of case managers' authority, both span and scope. These concerns are directly related to the way the V.A. is funded and the extent to which it will entertain the pooling of funds with other public programs in order to reduce fragmentation and enhance integration of service delivery. In effect, the V.A. represents a mixed case of the brokered and the consolidated models. To the extent that it makes referrals and arranges in home services from other providers, it will remain in the brokered category. It can move toward a consolidated model if it chooses to pool funding, perhaps within the limitations imposed by capitation and actually purchases a range of services on behalf of eligible individuals. Options that lead toward reduced fragmentation and enhanced integration of funding and service delivery will broaden both the span and scope of case managers' authority. If the V.A. chooses to create a partnership with community delivery systems, case managers' authority may be shared. This in part depends on the underlying structure of funding and the way in which veterans exercise their multiple eligibilities for public programs (e.g. Medicare, Medicaid, Older Americans Act).

The V.A. presents some interesting administrative features which make it an unusual laboratory for the development and testing of innovative case

management approaches. Robert Kane has written that the V.A.'s "network of services provides a large resource for patients. Because the whole effort is contained within a single system, it is possible to vary the way in which services are provided without withholding services from any individual."[18] In addition, creative combinations of medical care services and veterans benefits programs not possible in other delivery systems may make it possible to expand the range and scope of services available to needy veterans. The directions taken by the V.A. in the near future will be interesting to observe and will have direct implications for case management services designed to foster quality care for older veterans.

Conclusion

Case management has enjoyed widespread acceptance as a core feature of long term care delivery systems. Its very familiarity and acceptance potentially obscures the variety of ways the role is implemented and the relationship between the case manager performance and the service delivery context within which they work. Four long term care delivery systems were described in terms of their targeting, gatekeeping and financing features. It was argued that case management will vary with the characteristics of the delivery system in which it functions along four dimensions: span of authority, scope of authority, presence of financial incentives and centralization of resource control. Future analyses of case management in long term care should be delivery system contingent. Case managers perform core resource allocation tasks and translate delivery system constraints into care plans for clients. The character of these relationships deserves more focused attention and empirical investigation.

CHART 1

Delivery System Characteristics

	Targeting	Gatekeeping	Financing/ Reimbursement
Basic Channeling	No income restrictions 65+ 2 moderate ADL's/3 severe IADL's "Unmet needs" Community resident Catchment area resident Fragile social supports	"Improve access and coordination"	- Complete brokering - Small gap filling funds
Complex Channeling	No income restrictions 65+ 2 moderate ADL's/3 severe IADL's "Unmet needs" Community resident Catchment area resident Medicare Part A Fragile social supports	Expanded service coverage Authorization power Cap on average expenditures Limits on individual expenditures	Pooled Funding (state level) - Medicare (federal) - Medicaid (state) - Title 3 (state) Client Cost Sharing
S/HMO	Voluntary enrollment of "representative" elderly population	Single provider system for all services Provider risk Centralized authorization power Acute care linkage	- Prepaid rates prospectively determined - Medicare, Medicaid and private premiums pooled - Client cost sharing
V.A.	75+ 65+ Service-connected veterans Non-service connected veterans (?) Vulnerable, "at risk"		Prospective budgets by institution

CHART 2

Case Management Models

Variables	Channeling Basic	Channeling Complex	S/HMO	V.A.*
Span of Authority	Narrow	Moderate	Broad	Potentially Broad
Scope of Authority	Narrow	Moderate	Broad	Potentially Broad
Financial Incentives	Weak	Moderate	Strong	Potentially Strong
Centralization of Resource Control	Low	Moderate	High	Potentially High

* Since the V.A. does not currently provide case management for older veterans, this chart depicts speculative possibilities.

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1. Steinberg, Raymond and Genevieve Carter, Case Management and the Elderly: A Handbook for Planning and Administering Programs. D.C. Heath & Co., Lexington Books, 1982.

2. Len Gotteman and Barbara Schneider at Temple University are analyzing patterns in case planning from data generated by case managers in the National Long Term Care Channeling Demonstration.

3. Zawadski, Rilk T. and Marie-Louise Ansak. "Consolidated Community Based Long Term Care: Early Returns from the On-Lok Demonstration," The Gerontologist, 23(4), August 1983, pp. 364-369.

4. Callahan, James J., Jr. "The Channeling Demonstration, Summary Statement on Issues, Environment, Intervention and Outcomes," Brandeis University, V.H.P.C., March 1981, p. 1.

5. Basic sites: Eastern Kentucky (8 counties) Portland, Maine; Baltimore, Maryland; Middlesix County, New Jersey; Houston, Texas.
   Complex sites: Miami, Florida; Lynn, Massachusetts; Rensselear, N.Y.; Cleveland, Ohio; Philadelphia, Pa.

6. For a recent report on the Channeling Demonstration see
   Baxter, Raymond J. et.al. "Implementation and Early Operation of the National Long Term Care Demonstration: Overview" Mathematica Policy Research Inc., Princeton, New Jersey and Levinsor Policy Institute, Brandeis University, Waltham, Ma. December, 1983.

7. These services include: Day health and rehabilitative care, day maintenance care, home health aide services, homemaker/personal care services, housekeeping services, chore services, companion services, home

delivered meals, respite care, skilled nursing, physical therapy, speech therapy, occupational therapy, mental health services, transportation, housing assistance, adult foster care, nonroutine consumable medical supplies, adaptive and assistive equipment.

8. Diamond, Larry et.al. "Elder Care for the 1980's: Health & Social Services in One Prepaid Health Maintenance System," The Gerontologist 23(2), 1983 p. 148. See Appendix A of this article for a description of the Social/H.M.O. benefit package.

Four Social/H.M.O. demonstration sites are currently planning for implementation. They are: Elder Plan (Brooklyn, N.Y.), The Ebenezer Society and Group Health Plan (Minneapolis), S.C.A.N. (Long Beach, Ca) and Kaiser-Permanente Health Plan (Portland, Oregon).

9. For a discussion of the evolution of the V.A. system see

Sapolsky, Harvey M. and Stanley Wallack, "The Veterans Health Care System" in Federal Health Programs D. C. Heath & Co., 1981 pps. 195-201.

Thompson, Bruce and Richard W. Campbell, "When Government Delivers All Care: The Evolution of the V.A. Medical Program" in Health Policy and the Bureaucracy, M.I.T. Press, 1981, pp. 186-216.

10. Special Medical Advisory Group Task Force on the V.A. Geriatric Plan. Care for the Older Veteran, July 19, 1983.

11. Geriatric D.M. & S. Liaison Coordinating Committee, "Patient Treatment and Program Developments in the Care of the Aging Veteran," April, 1983.

12. Special Medical Advisory Group Report op.cit.

13. National Academy of Sciences, "Study of Health Care for American Veterans," report submitted to the Committee on Veterans' Affairs, U.S. Senate, 1977, p. 270.

14. Special Medical Advisory Group Report op.cit.

15. Durham, Mary and David Hopkins "Toward a System of Comprehensive Care for the Aging Veteran," GRECC, American Lake V.A.M.C., January 1983, p. 7.

16. For an in depth discussion of these concepts see Greenberg, Jay et.al., "A Comparative Study of Long Term Care Demonstrations: Lessons for Future Inquiry," (Minneapolis: University of Minnesota Center for Health Services Research, 1981) and Austin, Carol, "Case Management in Long Term Care: Options and Opportunities," Health and Social Work, 8(1), Winter 1983.

17. In October, 1983 the V.A. and Harvard Medical School sponsored a Conference on Options for V.A./Community Cooperation. A set of papers developed for this conference is forthcoming.

18. Kane, Robert, "Opportunities for Health Services Research in the V.A. with Regard to Care of the Aged," Symposium on Health Services Research Issues in the V.A., Chapel Hill, N.C., November 11-13, 1979.